

set her goals and to discuss her progress. The treatment team also should have regular meetings with the counselor to assess how the woman is progressing toward her goals. The goals should be very concrete and specific, so they can be measured. “Increasing self-esteem” is too vague. Goals should be specific to the individual and have a target date. For example, a goal might be for a woman, within 1 month, to stop retreating to her room instead of facing issues in group.

Treatment Recommendations and Strategies

The CSAT-supported women’s treatment programs have encountered a number of challenges as they have implemented their programs. Their recommendations and strategies for dealing with these issues are described below.

Issue 1: Uncertain client schedules and assignments

Programs in detention centers particularly face complex scheduling problems. Some of these include periodic disruptions to the program schedule caused by lock-downs and other security needs; patients being relocated or transferred during a treatment cycle because of overcrowding; and the difficulty of scheduling treatment because of the initial quarantine and impending trial dates. In county jails, the population is characterized by rapid turnover.

The CSAT grantees suggest both adopting a creative and flexible attitude and, if possible,

designing the treatment program for flexibility. This is an advantage for handling the uncertainties, but it also promotes a more individualized approach. Since the number of women involved in these programs is generally small, the more individual and flexible approach will serve the women better. Some strategies used by the women’s programs include:

- At the OPTIONS TC program in a county system, the program is designed in 8-week cycles; some topics are consistent across all cycles, but each cycle addresses the specific topics that fit the needs of the particular women in the group. In this system, new inmates can enter at any time in any cycle.
- Admission to the OPTIONS program is continual; a Newcomers group is used to orient new clients to the program. The Newcomers group permits staff to assess each new client’s needs, to assess potential adjustment problems, and to confer with other group leaders about appropriate client placement.

The WCI Village prison project director also points out that flexibility is important, because the models for treating incarcerated women are new. This is an underserved population. Experience and emerging research findings will suggest what is working well and what could possibly be modified. If staffs keep an open mind as they work with the women, they may come up with many new ideas for improving the program process.

Issue 2: Attracting clients to the treatment program

The women’s programs supported by CSAT have had few difficulties in attracting women to participate. At the Recovery In Focus prison program, for example, virtually 100 percent of the inmates volunteer to participate. At Forever Free, there are more applicants than program slots. One exception is a program where untrue rumors were circulated among the general prison population. This initial “bad press” has been overcome by orientation sessions when new inmates arrive, presentations in the living units, and by inmates’ observation of the program’s actual performance. A second program found their applicant pool was reduced when the corrections counselors, who were responsible for recruiting participants at the classification pre-screen, began to have different priorities.

Both Stepping Out, a jail program, and WCI Village, a prison program, consider it important to recruit the women into treatment immediately after their sentencing. Both programs hope to avoid having new inmates get negative messages about the program and other adverse effects from other inmates in the women’s living environment. Both these programs have also begun doing active recruitment within the living units.

The CSAT grantees report some of the major reasons women come to their programs include:

- The positive way they’re treated: Inmates see that the women are treated with

respect and caring in these programs—something that many have rarely experienced.

- Curiosity about themselves: In the Stepping Out program, the director said the women are very interested in the intensive assessment process and in discussing and finding out how they compare with other women.
- Meeting court mandates: Some of the programs help women meet the court-ordered requirements for reuniting with their children or treatment for themselves. Most of the programs have components aimed at advocating for and promoting the woman's self-interest: legal advocacy, child visits, counseling about parenting the children, and foster care for children.
- The individualized approach: One director stated that the "best hook" for bringing women into treatment is the individual type treatment her program offers.
- Fear and shame: Women who are incarcerated and taken from their families are often ashamed and humiliated; they are facing the consequences of their substance use and are eager for help.
- Self improvement: Many women in correctional settings want to take part in programs aimed at self improvement and personal growth.

Issue 3: Voluntary vs. mandatory participation

Nearly all the women in the programs described in this *Guide* enter treatment voluntarily. The exception is WCI Village, where

about 90 percent of the women are court-ordered and 10 percent are voluntary. At the Choices community punishment facility in Arkansas, some women are mandated to treatment by the

courts, and these women may voluntarily choose the CHOICES TC program. If treatment is refused, the court may opt for the prison alternative. If not mandated to treatment, women may select the Choices program or a less intensive drug education program.

At the Recovery In Focus program, the first group of women was mandated to the program (all women since then have been voluntary participants). This first group of mandated women was very angry about the situation. In dealing with this angry group, the project director came up with a highly successful strategy that now undergirds the entire program. The women were asked to help develop the new program and to be involved in key decisions—to help set the rules, the sanctions, the procedures that would be followed. Their anger melted and they eagerly took on responsibilities. Ever since, the women participants have had a strong voice in running this program, including self-monitoring (see table 7 in chapter 4). This program director recommends that women's treatment models use this strategy—allowing the participants as great a voice as

possible in running the program and setting and in upholding the rules and policies.

At WCI Village, where women enter the program on both a mandatory and a voluntary basis,

Rules are the backbone of any type of women's treatment program.

the program director says that this distinction is basically irrelevant to the treatment process. The women who come in on a mandatory basis are angry initially, but this dissipates in about a week. Both the mandatory and the voluntary participants are involved in a similar denial process; the voluntary group is no more "ready" for treatment than those who are court-ordered. The experience at WCI Village is that it takes all women—whether court-ordered or voluntary—about 2½ to 3 months to become emotionally engaged with the program and committed to it. At this point, the women begin to identify the critical issues in their lives, to move past denial and toward being in touch with their feelings, and to start really listening to other women who are past this early stage.

Issue 4: Program rules and sanctions

Rules are the backbone of any type of women's treatment program. They need to be stated in an absolutely clear manner, and the consequences of violating the rules should also be clearly stated. Other recommendations from the grantees follow:

- Rules need to be specific and, with this population, they must be consistently enforced by everyone—staff, security officers, and participants.
 - Goals for each woman need to be specific and individualized, with a time limit. The woman helps to set her own personal goals, and she is expected to be responsible for working toward and meeting those goals. Then if the woman does not meet her personal goals, she is in essence choosing not to stay in the program. This means that failure to progress in the program—and the decision to leave the program—is a choice made by the woman and shown by her actions. In this framework, women understand that failure depends on their actions; it is not a decision being imposed externally.
 - Institutional rules should not override program rules. In other words, if a woman “screws up” in the program, the institution should not impose extra days of incarceration or add some other sanction to her sentence.
- **Taking an individualized approach.** While a very concrete approach works with men, women want to deal with issues on an emotional basis. Women want an approach that is individualized to themselves.
 - **Building on women’s natural behaviors.** Men and women behave in very different ways while incarcerated. Men “do their own time.” Women tend to form their own “families” and informal networks while in jail or prison. Programs can successfully build on this need of many women to connect in a supportive way with others. The TCs actively promote a sense of the group as “family.” One of the programs also helps the women to identify who within the group they choose to relate to as parent and child figures, and to understand these factors in their relationships.
 - **Modifying the confrontation tone.** As discussed earlier, the authoritarian, harsh confrontation style of traditional male TCs is not appropriate for women. Many TCs for men, as well, have toned down their stark, “in your face” confrontation style. Research done by William Miller demonstrates that confrontation begets confrontation. That is, aggressive, “finger pointing” behavior by the staff leads to aggressive or avoidant behavior by the clients. Alternatively, empathic staff responses lead to more appropriate, participative behavior by clients.

The entire context of confrontation must be adapted for

women. To help gain a sense of empowerment, women do need to be assertive and they need to learn how to confront another person in an effective, assertive manner. The language used should never be degrading. From the standpoint of experiencing power, the women need to learn how to address issues with others in a frank, controlled, caring, assertive, and yet supportive way. Women can be very hard on each other, yet supportive at the same time.

Some women may need to have their natural confrontation style toned down. A California program reports that some women, especially young women from ethnic gangs, use aggressive body language and operate verbally on a very loud, hostile plane just short of violence. These women must learn that the way they relate at home and in their social group does not work in a treatment setting. And beyond that, the women need to learn alternate ways to behave while in treatment and at home.

- **Providing rewards and honoring achievement.** These women’s programs have found that honoring the women clients is very important for both the women participants and the staff. Both participants and staff need affirmation. Official ceremonies are affirming for the women, and they also help to encourage and bolster staff morale. Staff feel rewarded for each woman’s achievement. Among these programs, the

Issue 5: Environment suitable for women

In developing a program for women, it’s important to set up an environment in which women will be comfortable and thrive. This kind of environment helps to explain why the CSAT programs have been so successful at drawing women in and retaining them in treatment. Some of the critical elements that resonate with women include:

general practice is to have an awards ceremony when a woman or group completes each program cycle. There is also a graduation celebration when a woman completes the program. These ceremonies often include a cake, the awarding of a certificate, and official recognition from the podium by staff and other participants. Several, such as the OPTIONS program, also have anniversary celebrations for their graduates. These are gala events that renew ties with the graduates and offer inspiring role models for the current program participants.

These events bring the community together as a bonding experience. Some suggestions from the CSAT programs: have a play day for the annual celebration, with picnics, games, and festivities for fun. The Recovery In Focus program has found videotaping to be very popular with the women. They videotape the award ceremony and videotape the women as they're involved in the play day games and other activities. At the end of the day, the videotape is played for everyone to enjoy.

At the OPTIONS program, a project committee is used to involve all the women clients in planning some special project, such as a play, a graduation presentation, or a program newsletter.

Issue 6: Handling denial issues

Working through a woman's denial is a central hurdle for treatment programs. The pro-

grams described in this *Guide* view denial from two different perspectives, and therefore deal with it somewhat differently. Planners setting up new programs are also likely to use one or the other of these approaches.

The first approach represents the traditional 12-Step model, in which denial is seen as a symptom of the disease, with the person blocking out and refusing to accept the reality of his or her substance abuse problem and the negative effects this has on self and others. Confronting and breaking through that denial is perceived as central to recovery. For those using this 12-Step approach, the CSAT grantees made the following suggestions.

- **Self-esteem issues.** The Forever Free program has tested the self-esteem ratings of their women participants as they enter the program and then move past the denial stage. The scores show that self-esteem, already very low in these women, plummets virtually to zero as they face the overwhelming reality of their substance use problem and their own deficits. The program director emphasizes how vulnerable the women are at the stage when they break through their denial. The recommendation is to provide every possible means of support to the women during this period. At the Forever Free program, breaking through the denial is the low point in self-esteem and then the women's scores begin to rise.
- **Support strategies.** At WCI Village, the program is set up so that women do not feel iso-

lated or alone when they face through their denial. The program director says that, if a woman is to break through her denial, she must have support. Whether standing to address the group or sitting in a circle, the woman has a buddy who is beside her to offer support, either verbal or through touching. This support person is there to say, "you're OK," "we're here to help you get better." The particular support person rotates so that all the women in the group are taking part in what is designed to be a supportive and nurturing environment.

The second perspective, based on a therapeutic model, addresses denial in a different context. In this perspective, women are not seen as denying their addiction and its consequences. Instead, women are seen as ambivalent about giving up their substance use because they are deeply attached to it. The addiction is functional for these women. For many, it is numbing their depression and the pain they feel in their lives and from abusive relationships, present and past. As one woman client said, "Alcohol is the only thing in my life I have control over; when I drink, I know just how I will feel." It is a dynamic similar to that for domestic violence. It is not helpful to say to a woman who is being abused, "just leave the guy." The woman has too great an investment in the relationship—or is too dependent on it—to let the relationship go.

In this perspective, a woman is denying and ambivalent because she has a compelling attachment

to the drug. There will be grief and loss at giving it up. The way to help clients is to help them address the nature of their attachment to drugs. What is the woman getting out of it? Why is the need so compelling? How does this attachment affect her individually? With this perspective, the approach is to explore these issues of attachment, grief, and loss. Confrontation would be used only when working with highly antisocial women.

Issue 7: Addressing intense emotional issues

A very high percentage of addicted women offenders have experienced physical, emotional, and sexual abuse. Some have abused their children. These are intense and emotionally charged issues for the women. If women do not deal with these issues in their lives, they are at increased risk of both relapse and recidivism.

The issue for treatment programs is how best to address these topics. Several of the programs urge great caution. Counselors need training in how to work with women on these issues. Women often have great difficulty acknowledging the abuse that has been done to them and may be very disturbed when facing this. However, these issues are so central to a woman's recovery that they must be acknowledged and addressed.

The CSAT-supported programs suggest two principles. First, don't ever brush off this topic when it comes up. If it can't be handled within the program context at the particular time, then it should be acknowledged as a serious issue important for

recovery. The woman should be given next-step options for how and when she can be helped with this. The second principle is "guided self-disclosure." Women are not pushed to bring up this topic. They are instead given opportunities to bring it up as an issue, such as through the counselor's inviting of comments or open-ended questions.

Following are suggestions for handling these emotional issues at different stages in treatment.

- **During screening and assessment.** The screening process should not ask questions about traumatic emotional issues unless the program expects to help the woman deal with them. Such inquiries should not be made if the woman will be going on for treatment elsewhere. Some program directors questioned whether taking a history of physical or sexual abuse is appropriate during screening, since such abuse is so widespread for these women. Early in the program, some women don't even realize they have been abused. Others lie about it initially. As one director put it, "This topic comes out naturally during the group work; there's no need to ask about it during screening."

Some screening instruments are set up to elicit research-oriented yes/no counts; this approach is not desirable. Instead of simple "yes"/"no" responses, women should feel encouraged to discuss their issues. When emotional issues are asked about during screening, it is suggested that an invitational tone be used, so the woman can answer any way

she wants. For example, "Many of our women have experienced physical or sexual abuse. Is this an issue you wish to discuss right now?"

- **In short-term programs.** For short-term programs, which do not have the time to work through these intense emotional topics with a woman, it is recommended that the topic not be glossed over for any woman who brings up the issue. Rather, the issue should be briefly processed. It needs to be pointed out that (1) this is an important issue affecting many women who have addiction problems, and (2) it is critical for a woman's recovery that she talk about and have help in dealing with any physical, emotional, or sexual abuse in her past or current life. This should be used as an encouragement for the woman to enter community treatment—that she will receive help with this when she goes for more extended treatment. Referrals should also be available.
- **In mid- and long-term programs.** In mid- and long-term therapeutic communities, abuse and victimization issues need to be dealt with in depth. At WCI Village, the project director says that it would stigmatize the women to have separate process groups for sexual and physical abuse or for those with the human immunodeficiency virus (HIV). Abuse is such a pervasive problem for everyone that it is a theme in the ongoing flow of group discussions—"this is something that happened in your life, that happened in the lives of most

people here.” The effect of feelings, like depression, is another pervasive theme throughout.

Staff of the Forever Free Program in California point out that, in focusing on sexual issues, it is important not to de-emphasize other forms of abuse, such as physical, emotional, or psychological abuse. Although 90 percent of the women in the Forever Free program have experienced sexual abuse and this becomes the program norm, there is a sub-category of this abuse that is even more severe. It involves primary sexual abuse coupled with a secondary form, such as psychological abuse. An example would be a person who was sexually abused and locked and restrained in a closet for a long period of time ... suffering some sensory deprivation as well. This more severe, multi-level abuse may raise issues beyond the treatment capabilities of some drug treatment programs, depending on the counseling/therapy capabilities of staff. Such problems may require a referral to psychiatric counseling as well as work within the drug treatment program.

Most of the CSAT-supported programs have been able to refer women to psychiatric services when they may need additional help. Having a staff member with expertise in mental health issues is an advantage for identifying and caring for such women.

Issue 8: Retaining women in treatment

Research shows three important facts about treatment outcomes:

(1) successful outcomes are related to how long a person stays in treatment, (2) women generally are not retained in treatment at as high a rate as men, and (3) retention tends to be a problem in TC programs. A program’s ability to retain a high rate of its woman participants until they complete the program is therefore critical.

The in-custody programs described in this *Guide* are quite new programs. Although all but one of these programs are voluntary, none is reporting significant retention problems. Those reporting on actual data show very successful results in being able to retain the women in the programs. Examples include:

- **Baltimore Detention Center pre-trial program:** Graduation rates have been steadily rising. Currently, 90 percent of the women graduate from this 2-week program.
- **Forever Free prison program:** A review of 2 years of Forever Free program data shows that more than 92 percent of women admitted to this 4- to 6-month treatment program complete it.

The WCI Village program director has the following comment about retention, “Once we help the woman get past her first difficult issue—whatever that is, whether it’s being abused herself or abusing her child—then that woman stays.” However, TC programs such as WCI Village are intense and require a high level of personal commitment. Some women do drop out. WCI Village now offers drug education classes for women who drop out of the program so they have some

continued involvement on alcohol/drug issues.

More severe retention problems are likely to occur at the community level, after women offenders are released from prison or jail. This issue is discussed later in this chapter.

Issue 9: Sustaining motivation until discharge into the community

When a participant completes an in-custody treatment program, the person should not be returned to the general population of the prison or jail. This is a lesson learned from women in the Stay N’ Out program and in many programs for addicted male offenders. Experience shows that treated offenders need to move on to the next stage in the rehabilitation process right away. When they are returned to the general population and must wait for release, people lose their treatment gains.

In all the CSAT-supported women’s programs, every effort is made to admit women in conjunction with their anticipated release dates. However, women do not move through treatment at the same pace, so the date when they will complete treatment can’t be exactly predicted. There are also many uncertainties and changes in the dates when inmates are released.

The grantees have developed a number of strategies for the many cases in which women have completed treatment, but must wait in the institution for release. (The best option, of course, is for the sentence to be tied to completion of treatment, so the woman can proceed

directly from completing her in-custody treatment program into community-based treatment and supervision.) These strategies include:

- **Separate dormitories.** Several programs have been able to arrange for separate buildings or dormitories to house women who have completed treatment. This includes the 2-week Baltimore detention center program, the Choices community punishment facility, and WCI Village—where program graduates live in an independent living program for trusted, long-term women offenders.
- **Senior program positions.** At Recovery In Focus and WCI Village, graduates can stay on as senior residents and mentors, continuing to be involved in the treatment program. New job positions were created for these women at WCI Village, which also strengthened and enhanced the chain of command. These positions include resident counselor, house monitor, facility manager, coordinator, and senior coordinator. Seniors run groups and take part in the program. However, expanding top positions in TCs can only go so far. If too many veterans remain at the top of the seniority structure, this will shut down opportunities for other clients to progress into positions of increased responsibility.
- **Continued services.** In the Baltimore detention center program, women still in custody after the 2-week program participate in a weekly acupuncture aftercare group

and in twice-weekly psychosocial aftercare groups.

- **Transfer to other programs.** Recovery In Focus is able to transfer some graduates to another treatment program; some can also go to a work release program.
- **Specialized program positions.** The WCI Village program has had difficulty recruiting Hispanic staff. One of their Hispanic program graduates, while waiting to be released, has been able to help fill this gap. She has translated their program manual and procedures into Spanish and now teaches Spanish to women in the program. She may next offer Spanish classes to the entire prison population.
- **Institution jobs.** WCI Village has been able to place program graduates in prized institutional office jobs, like receptionist positions. This gives the women job experience and is a visible sign to inmates in general about advantages of being in the program. However, the project director cautions that the correctional staff may need training about how to interact with these program graduates. Initially, the correctional staff overreacted by giving the women gifts, treating them as “special,” and engaging in enabling behaviors.

Stage 3: Transition/Pre-Release Planning

Research and experience identify the first 90 days after an offender’s treatment and release from

custody as posing the greatest risk of relapse, “when clients are exposed to drug-related stimuli, without the support of a structured program to help resolve their conflicts” (Leukefeld and Tims 1988, pp. 1-7). Pre-release planning for this transition period is absolutely critical for women offenders. As one project director put it, “Many of our women clients cannot make it on their own [in the community]. We must identify these women and get them proper help and resources before they leave.”

Case Management in the Pre-Release Period

Throughout the correctional treatment process, two important themes are (1) to motivate the woman to enter community treatment and to involve herself in 12-Step or other mutual-help groups after her release, and (2) to identify the social, economic, and vocational problems that need to be resolved to help the woman remain drug- and crime-free. Case management and planning in the final weeks before the woman’s release need to focus on, and advocate for, actual links to services. Major links involve:

- **Connections and individualized planning with probation and parole officers,** so that correctional requirements can be met and, whenever possible, the parole process will reinforce treatment goals.
- **Connections and individualized planning with community treatment providers,** so that there is continuity between a woman’s in-custody treatment

and the treatment she receives in the community.

- **Connections with local service networks**, so that the woman has the ancillary services she needs. The most important of these are safe and drug-free housing, child care for her children during her treatment, vocational training and job-hunting assistance, and economic help until she is employed.

The director of the North Rehabilitation Facility suggests that the planning process with the woman should not be a checklist-type operation. It needs to be an in-depth exploration of what the woman feels she needs to remain drug- and crime-free. She recommends that this process involve a housing case manager, a mental health specialist, a person expert in financial and welfare aid, treatment beds available on contract, and a strong job/vocational component. Access to care is a universal problem for women, unless they're pregnant. (The message this may send to women is that they're only important in their maternal function, not as a person.)

Transition From Prison Programs

For the CSAT-supported prison programs described in this *Guide*, there is a strong transition planning component that operates through the State's corrections or community punishment departments. This transition phase is supervised through probation and parole functions and, in some States, continuing treatment is mandated for some or all of the women being released.

Many women offenders' pressing need for services comes after this transition phase, when they are in the continuing care phase. The transition phase is structured as follows for the CSAT prison grantee programs:

- **Oregon.** Women can leave the Recovery In Focus program only to go to community treatment programs—either residential or outpatient. The State corrections department puts women on probation/parole into treatment, with costs picked up by the Oregon health plan or by the counties, using CSAT block grant moneys. There are correctional treatment beds in the counties and also resident and outpatient work release facilities (until recently, there were nine work-release beds for women at the Multnomah County YWCA). For compliant women with long sentences, there is a structured program that combines work release, job search, and outpatient treatment. The In Focus program follows the women for 30 days, and a transitional specialist monitors the women for the 6 months of work release. Volunteer mentors then work with the women during the aftercare period (up to 1 year), reporting to the transition specialist.
- **California.** Women in the Forever Free program are encouraged to volunteer for post-release community treatment, with a program placement goal of 50 percent. Multi-funding sources are available, including a component from the California Department of Alcohol and Drug Programs, which tar-

gets four southern California counties and contracts with nine residential treatment facilities. A new referral component, recently funded by California's Department of Corrections (DOC), now provides treatment dollars for placement within any California county or licensed treatment program. The primary objective is placement in a full-time residential treatment facility for up to 6 months. Two full-time staff—1) a DOC employee who is a Parole Agent, and 2) a contract employee who is a Recovery Advocate—dedicate their time to transitioning participants into community treatment. Forever Free reports that it is essential for the client to be transported directly to the residential facility upon release. Transportation is always scheduled or provided directly by the Parole Agent.

- **Delaware.** Delaware, a small State, has been restructuring its correctional system to provide a continuum of services for substance-abusing offenders. This continuum will provide treatment and supervision at all stages, from detention through in-custody treatment to structured work-release and supervised aftercare. The WCI Village TC for women is one element in this evolving, integrated system. Treatment Alternatives for Safer Communities (TASC) provides a case management function for the WCI women, both before and after they are incarcerated. The Delaware transitional work-release component is described in the next section.

- **Arkansas.** Choices staff, part of a new community punishment facility, conducted an education effort with judges and parole administrators. The court now orders women into treatment for a minimum of 90 days, and the women may select the Choices program. There are post-prison transfer board orders and judicial transfers to the Department of Community Punishment (DCP) if a woman is eligible for treatment. Some orders extend into the community, with treatment recommendations passed on to parole officers. The DCP pays for substance abuse treatment, mental health services, and general equivalency diploma (GED) preparation. This is done through DCP contracts with statewide substance abuse and mental health providers across the State.

Only outpatient treatment is available for women in Arkansas. Since there is just one drug-free living center for women in the State, many women are returning to undesirable living situations. Choices staff work with the women's families whenever possible to gain their support for the women.

Transition From Jail Programs

For the CSAT women's jail programs, the transitional period after release tends to have less systemwide structure than for prison programs. The jail programs tend to be more involved in actually developing and running post-release services for the women. Since so few residential treatment facilities are available, housing for the women is a cen-

tral issue. In addition, the jail programs often maintain a continuing support function, setting up support groups and other ongoing activities for their graduates.

The Stepping Out program in San Diego has a particularly comprehensive strategy to prepare women for the post-release transition period. This program includes the following components:

- Staff from treatment programs in the area come to the jail on a monthly basis to talk about their programs.
- Staff from these community programs come into the jail to screen the women for entry into their programs.
- A staff person from the community treatment facility where the woman will be going meets with the woman and her in-custody case manager before the woman's release; the client and this staff person mutually agree on her community treatment and make a personal commitment to this treatment.
- For women going to outpatient treatment, Stepping Out arranges and pays for 30-45 days of living in a drug-free environment, either through their own houses or through a San Diego network. Housing is subsidized only if the woman is in treatment.
- For women going to residential treatment, there is often a waiting period of several weeks before a treatment slot becomes available. Stepping Out develops an interim plan for this waiting period that includes housing in a drug-free

living house and outpatient treatment.

- The aftercare program connects the women with a network of other services. This network includes community service agencies, employment, and acupuncture. A planning forum of service providers takes place during the 1 week before and 1 week after each woman's release. This forum identifies and prioritizes the woman's needs. Primary needs are delivered first. These include clothing, food, housing, and personal hygiene products.
- The women are picked up by car and taken to their new treatment settings.

Important Principles in Transition Planning/Supervision

The women's programs described in this *Guide* offer a number of strategies for dealing with key issues in the pre-release phase.

Issue 1: Voluntary vs. mandated participation in community residential/outpatient treatment

Although some women offenders are currently mandated to post-release treatment, many are not. The reality is that, on a voluntary basis, a great number of women offenders who need treatment do not get it. For example, at the OPTIONS county program in Philadelphia, all women who leave the treatment center are given referrals to community agencies. However, only 45 percent actually attend treatment. At

the Forever Free prison program, where all the women are encouraged to enter community residential treatment, one-half of the graduates choose to enter residential treatment; some also enter community outpatient treatment. At the Baltimore detention center, all women are encouraged to enter community treatment. About 25 percent of the women are sentenced to prison instead of being released at the time of trial. Of those released, roughly 47 percent go into community treatment.

Two of the CSAT programs report good results in raising the percentage of women entering community treatment. Stepping Out made a real effort to prepare women for the transition into other treatment programs, not in the abstract, but in the transition to the particular program that the woman will be entering (see the description above). These efforts have reduced the attrition rate. The Baltimore program is having excellent results in increasing the number of women in treatment by means of a new court-based project, a special project of the Alternative Sentencing Unit. This project offers sentencing inducements for entering treatment combined with intensive case management and outpatient treatment.

Clearly, a higher percentage of women offenders engage in community treatment after their release when treatment is mandatory rather than voluntary. They also stay longer in treatment. With this population, mandating treatment along with supervised sanctions, such as regular urinalysis, may be the most effective way to promote

recovery and a crime-free lifestyle. But the move toward more universal mandatory treatment for women needs to be done with full awareness of the ethical and possibly legal issues involved. For example, is it ethical to force women into mandatory treatment for longer periods of time than their crime would

otherwise exact? Another ethical issue relates to the scarcity of community residential treatment facilities for women. As a society, we certainly don't want to have to incarcerate women because that's the only place where they can receive adequate treatment. CSAT's TIP 17 on planning treatment for adults in the criminal justice system (CSAT 1995a) offers an overview of these ethical issues.

Issue 2: Critical importance of immediate placement

Upon release, the women need to go immediately to their treatment centers. As the In Focus director points out, "Even waiting a few hours, you can lose them." One of the CSAT-supported programs experienced a tragic example of this. A program graduate agreed to enter residential treatment in her community but she wanted first to spend the weekend with her boyfriend. That weekend she died of a drug overdose.

Several of the CSAT-supported programs physically transport

women to their new treatment facility. These programs include the SISTER project, Stepping Out, In Focus, and Forever Free. The Recovery In Focus program recently lost the use of the State cars used by staff to take women to their new treatment sites across the State. The program now makes arrangements for the

**Once a woman is released,
she should go directly to treatment.**

women to travel by bus, and their new treatment provider will be there waiting at the bus stop to meet the woman when she reaches her destination.

Issue 3: Waiting lists

Once a woman is released, she should go directly to treatment. If there is a waiting list, then an interim plan needs to be devised. At Stepping Out, such a plan would include safe housing, ongoing supervision, acupuncture, and short-term treatment support.

Issue 4: Handling relapse

Addiction is a chronic condition. As anyone who has tried to give up smoking knows, it may take several or numerous attempts, with lapses between, to completely give up cigarettes. These women can be expected to have lapses and relapses. Relapse prevention therapies have become increasingly concrete and adept at training people to recognize their own personal cues of impending lapses and to cope with them. The SISTER project

devotes time 5 days a week to work on coping with relapse.

In some jurisdictions, probation and parole officers receive special training in how to case manage women with addiction problems. Probation/parole officers, if they are knowledgeable and skilled, can be instrumental in helping paroled offenders weather relapse episodes. What is needed when a woman relapses is to increase the level of services. However, many jurisdictions do not take this approach. Instead, they use relapse as a technical reason to return a woman to custody. The CSAT grantees suggest the following strategies:

- Work with both the woman's community treatment provider and the probation/parole officer. Both should get the same paperwork—the woman's assessment, relapse prevention plan, and the prognosis.
- Make sure each woman leaves with a specific relapse-prevention plan that lays out the behavioral specifics crucial to her in recovery. Both the woman and her parole officer can then recognize the signs that she is needing extra help.
- Have a personal conversation with the woman's probation/parole officer; the officer must make sure that the woman becomes connected to Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or other mutual-help group meetings. At Choices, each woman's probation/parole officer is sent her discharge summary and program recommendations, along with the information given her about local AA/NA contacts.

- Give the woman, before she leaves, a list of names and addresses for AA/NA support groups in her area and ask the woman to attend. At jail programs, a person from local AA or NA chapters can visit and make contact with the woman before her release. This is a natural contact if the jail already has mutual-help group meetings at the facility.

Issue 5: Integrating in-prison treatment with community-based care

It is very desirable to have a continuum of treatment planning between the in-custody program and the community program. The CSAT grantees have used a number of strategies to link their programs with community treatment and other services. These include the following strategies:

- Invite treatment providers to come into the facility to screen women clients for the program, and work with them to develop a coordinated ongoing treatment plan for each individual woman. In Focus, Stepping Out, and the Baltimore Detention Center all do this.
- After obtaining consent of the client, provide the new treatment provider with detailed paperwork and other communications about the woman.
- Share training and cross-training events with community providers.
- Look for opportunities to work as a team; an example would be the forums that Stepping Out holds before and after a woman's release to identify and prioritize her needs.

- Bring community service representatives into the facility to tell about their services. The OPTIONS program, for example, in 3 years has had 145 seminars given by 70 community representatives from many different agencies and disciplines.

Issue 6: Mobilizing women to enter treatment programs

Motivating women to want to go into community treatment is a theme of the short- and mid-term in-custody programs, as already explained. But when it comes to a woman's actual decision, in the critical pre-release period, CSAT grantees suggest several strategies. Most strategies reflect the fact that the women are frightened and in crisis; they need to feel that they will be safe. Women offenders want to know where they will be going, how they are going to be treated, who will be the people involved in their treatment, and what will be expected of them.

- **Bonding with the new caregiver.** Most critical is that the woman gets a chance to meet a person from the new treatment program. Stepping Out says that this needs to be a personal bond. The In Focus program has found that, since community treatment providers have come to the prison to do their screening and to meet with each woman client ahead of time, the length of time that women stay in community treatment is lengthening.
- **Making a one-to-one commitment.** The new caregiver needs to get a commitment from the woman client, a promise about the appointment. "We're

counting on you for next week.” The staff member from the new program also must make a commitment to the client. “Yes, I’m the one who will be there for you.”

- **Visiting the new program.** One project manages to arrange for a woman client to make a visit or to spend a weekend, so the woman can see the new program in advance and meet other participants. This is also helpful if the woman is going to a work-release center.
- **Meeting child care needs.** Whether the woman goes to residential or outpatient treatment, she will have to resolve child care issues first. One project has arrangements for child care through women in an Oxford House. (The Oxford Houses are a national network of self-run, self-supported recovery houses for individuals recovering from alcohol or drug addiction; see “Program Materials” in the Resource List for the address of Oxford House, Inc.) The SISTER project offers a legal liaison who advocates for the woman regarding custody issues. This legal advocate also prepares women for their court appearances and advocates to get the women into treatment instead of jail or prison.

Stage 4: Post-Release Treatment and Continuing Care

The prison and jail demonstration programs described in this *Guide* are designed to serve

women in custody. For women offenders with serious, long-term drug abuse problems, in-custody treatment offers a valuable window of opportunity for motivating the woman into substance abuse treatment. The period of incarceration provides a period of relative stability, giving

women the breathing space to look at themselves and their addictions and to begin the difficult process of changing their lives.

In-custody treatment can be critical for these women. However, this treatment and supervision is only the beginning. Practitioners agree that women offenders must have help during the transition to community life. Most women offenders with substance abuse problems successfully manage to be abstinent and drug free during the structured jail or prison period. Remaining abstinent in the community, without any structure and while facing myriad personal and economic problems, is much more difficult. Women’s program directors on the CSAT expert panel stressed that women offenders with drug problems are not receiving the structure, support, and time they need to rebuild their lives after leaving the institution.

The experience of the CSAT grantees supports the conclusion of a number of experts—that one of the most feeble links in the

criminal justice system is the connection between rehabilitation efforts in prison and the process of integration into society after release (Wexler and Williams 1986). A national 1992-93 mail survey of jail and prison programs that provide drug treatment and other services to

Women offenders must have help during the transition to community life.

women offenders found that more than 90 percent of these programs encouraged women to begin or continue attending 12-Step meetings, and more than 80 percent said they made arrangements for continued care in the community. But fewer than half of the prison and jail programs reported providing other transition services from custody to the community, such as housing, income, medical care, or follow-up contacts (Prendergast et al. 1995).

The Bureau of Justice Assistance has concluded that “women have a more difficult time integrating into the community after release than men do. This is because women are likely to be at a more advanced and severe stage in their substance abuse when they are incarcerated, and because women suffer from a broader range of problems, including more medical and mental health problems, educational deficits, a lack of vocational skills, and more complicated family and community relationships” (BJS 1994).

Components for Post-Release Transition to the Community

A broad range of concrete experience with addicted offenders suggests that, in the period after release from prison or jail, the person with a history of chronic drug use will need the following components:

- **Continuing treatment for drug abuse.** This may be primary treatment subsequent to an in-custody motivational program, or less intense continuing treatment for those who received primary residential treatment while incarcerated. The principle is that the offender continues in treatment, at ever decreasing levels of intensity, until the person's recovery and crime-free lifestyle are stabilized. Most programs plan a process lasting 6 months to a year.
- **Probation/parole supervision.** Regular urinalysis is an important part of this supervision, to ensure that the offender remains drug free and to trigger immediate help for a relapse. It is an enormous advantage to have ongoing treatment required as a sanction by the criminal justice system during this period.

One Federal research demonstration project designed to offer highly intense case management and outreach to offenders during post-release concluded, "Without an external force making sure they attend [treatment] when first released from prison, there is little that can be done to help clients internalize the motiva-

tion to stay in treatment and to stay clean" (Martin et al. 1995). For this research project, the inability to require participation in treatment—either as a means for early parole or as a *condition* of parole—severely impacted on retention (Martin and Scarpitti 1993).

- **Case management to ensure services.** Case management is critical for providing coordinated services at transitions between stages of the justice system. Case management needs to provide a way of linking the treatment and criminal justice systems, ensuring that offenders meet both their criminal justice and treatment requirements. Case management services have also been found to enhance retention in community treatment among drug-involved offenders, an outcome that is closely linked to reduction in recidivism (Hubbard et al. 1988). In addition, a case manager is needed to link the women with other needed services.

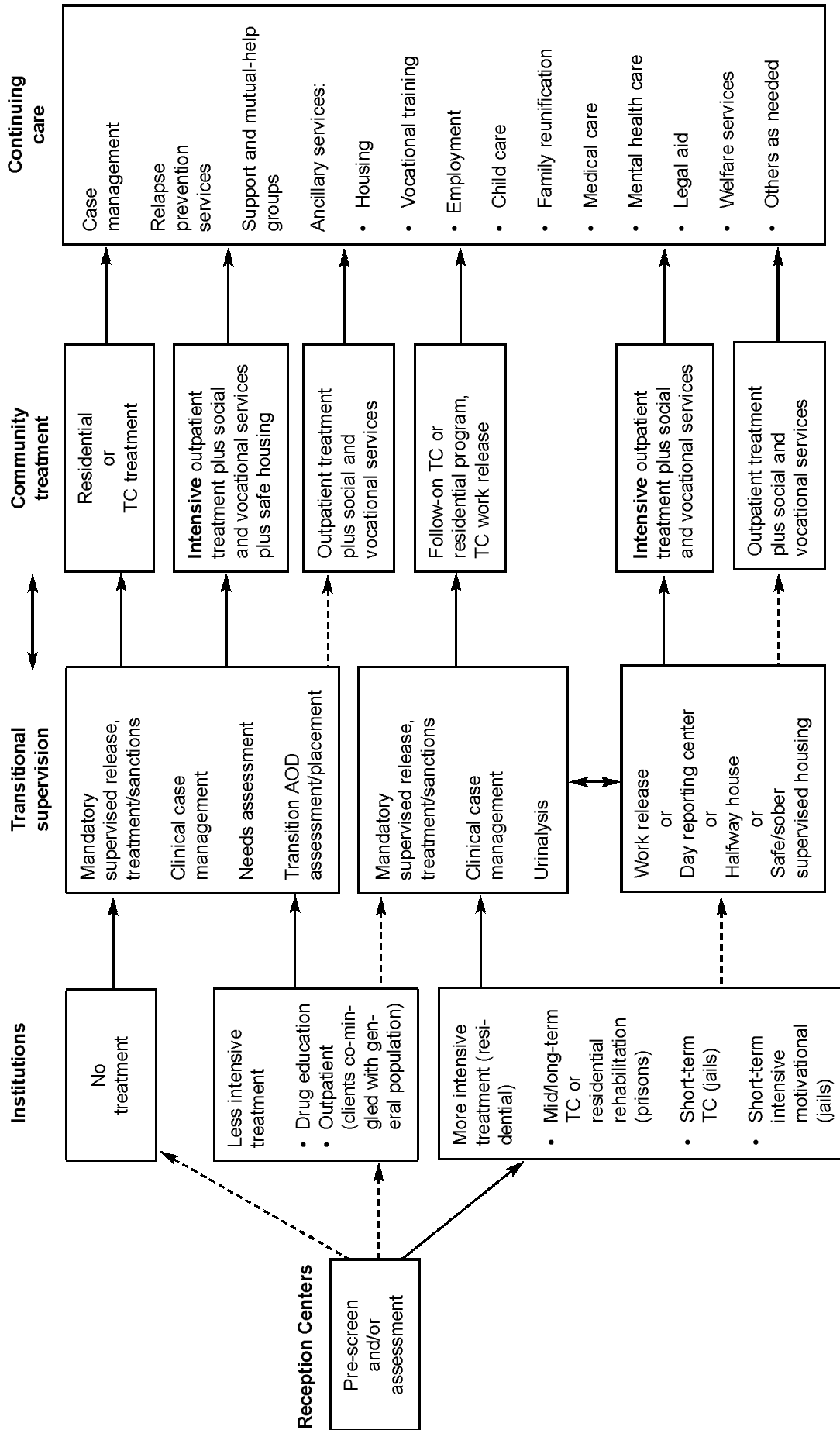
Those in residential treatment will have their housing and other needs met while they are in treatment. But after release, and for women who go from custody directly into outpatient treatment, there are immediate, pressing needs for such services as medical, dental, and mental health care; child care and assistance in maintaining custody; housing; educational and vocational training; legal aid; and assistance in obtaining any potential entitlements, such as Medicaid and public assistance.

- **Participation in mutual-help and support groups.** The follow-up studies show that the addicted offenders who remain longest in treatment—the group most successful on parole—also have the highest participation in AA, NA, and other mutual-help groups. These groups serve as therapeutic bridges from incarceration to the community. Relapse prevention is a major concern for recovering addicted clients, and a supportive group of non-using peers is clearly an important asset. Other appropriate mutual-help groups for women offenders could include Women for Sobriety, Survivors of Incest Anonymous (SIA), or Rational Recovery. However, these groups are not a form of treatment, and attendance at meetings should not be used as a sanction (CSAT TIP 17, 1995a).

Various Paths for Women Upon Release

Research suggests that community-based aftercare is necessary to reinforce the primary treatment initiated in prison. Women need a continuum of care upon release into the community. Table 12 shows the various paths that a woman may take, depending on the individual's need, the intensity of treatment received in custody, and the care available in the community. The type of treatment provided should, if at all possible, be consistent with the treatment philosophy used in the corrections treatment program. Major paths are described on the following pages.

Table 12. Paths into community treatment from institutional programs for women offenders with chronic, severe AOD problems



Code:
 Solid lines represent more desired paths of treatment/supervision.
 Dotted lines represent less desirable optional paths.